DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10115 (01/03) (Formerly DES 2096)

STATE OF WISCONSIN
Federal Regulations 42 CFR 433.138

MEDICAID HEALTH INSURANCE INFORMATION

1. Do not write in shaded areas (for office use only).
2. Policyholder is to complete this form. Answer ALL questions. Write "NONE" if a question does not apply to you.
3. Policyholder should list all persons in Section A who are applying for or are now receiving assistance, and are covered by other health insurance, whether or not the policyholder resides in the household.
4. Policyholders completing this form who are not living with eligible dependents must list in Section A all dependents who receive assistance.
5. Use a separate form for each carrier/policy. Ask for additional forms.
6. Once form is completed return to your local county/tribal social or human services department.

FOR OFFICE USE ONLY

Casehead Name	**Case Number**	☐ **IM** ☐ **CS**
TPL Transaction - Information Being: ☐ **Added** ☐ **Changed or Ended** ☐ **Deleted**	**Agency Code**	**Worker Code**

Section A - Recipient

Medicaid ID Number	Name (Last, First MI) (List **all** persons who are applying for Medicaid and are covered by the policy described in Section C.)	Birthdate (mm/dd/yy)	Relationship to Policyholder (Check one) 1-Self 2-Spouse 3-Child 4-Stepchild 5-Other	
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Reset Line 1
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Reset Line 2
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Reset Line 3
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Reset Line 4

Section B – Policyholder Information

Type of Policy ☐ Major Medical ☐ HMO / HMP/ PPO ☐ Medicare Supplement ☐ Accident ☐ Other

Is Policyholder an Absent Parent? (Parent who is continuously away from the home.) ☐ Yes ☐ No

Policyholder Name (Last, First, MI)	Social Security Number*	Birthdate (mm/dd/yy)

Policyholder Address (Street, City, State. Zip Code)

Section C – Insurance Information

Insurance Company Name

Insurance Company Address (Street, City, State, Zip Code)

Policy Number	Policy Start Date (mm/dd/yy)	Policy End Date (mm/dd/yy)	Group Name	Group Number

Section D - Employer Information (Complete if Policyholder is Employed)

Employer's Name	Telephone Number

Employer Address (Street, City, State, Zip Code)

Should Insurance Claims be sent to the Employer? ☐ Yes ☐ No ☐ Unknown	Medicaid Program Use Only - Insurance Company or Employer Billing Code

I understand that as a condition of eligibility for Medicaid I must report to the county/tribal social or human services department any other person(s) that may be liable to pay for medical care for my family and me. I must also cooperate by giving information to assist the county/tribal social or human services department in pursuing payment from any other person(s). I understand that any benefits for the cost of medical care which are available under a policy will be assigned to the State by law (s. 632.72, WI Statutes.) during any period of Medicaid eligibility. I understand that within 10 days I must report any changes in all of the above information. The information given above is true and complete to the best of my knowledge.

SIGNATURE – Policyholder	Telephone Number	Date Signed

* Providing or applying for a Social Security Number (SSN) is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to s. 49.82(2), WI Statutes. Your SSN is used for the administration of the Medicaid program.

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